Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal

The State of Delaware, Department of Health and Social Services proposes a section 1115 demonstration entitled Delaware Healthy Adult Program, which will increase the number of individuals with health insurance coverage.

I. GENERAL DESCRIPTION OF PROGRAM

The Delaware Healthy Adult Program, which is scheduled to begin on October 1, 2002, will provide health insurance coverage to an additional 7,075 residents of the State of Delaware with incomes at or below 200% of the Federal poverty level. The increased coverage will be funded by current State and Federal SCHIP allotment shares and required program premiums.

II. DEFINITIONS

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of net income, adjusted in accordance with the state's existing deductions in the Delaware State Health Plan and the Delaware Healthy Children Program.

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

_X_ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

_X_ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

_X_ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

_X_ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

_X_ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

_X_ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.
The HIFA waiver contents will be discussed with the Medical Care Advisory Committee (MCAC) at its June, 2002 meeting. Other public input will be requested prior to implementation of the project, as required.

IV. STATE SPECIFIC ELEMENTS

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 200 percent of the FPL. The existing deductions in the Medicaid and Delaware Healthy Children Programs will be used to determine the countable income that will be compared to the upper income limit.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX.)

_____ Section 1931 Families

_____ Blind and Disabled

_____ Aged

_____ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

__X__ Children and pregnant women covered in Medicaid above the mandatory level
Pregnant women between 133% and 200% FPL

_____ Parents covered under Medicaid

_____ Children covered under SCHIP

_____ Parents covered under SCHIP

__X__ Other (please specify)
Section 1931 between 65% and 75% FPL

Medically Needy

_____ TANF Related

_____ Blind and Disabled

_____ Aged

_____ *Title XXI children (Separate SCHIP Program)*

_____ *Title XXI parents (Separate SCHIP Program)*

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

_____ Children above the income level specified in the State Plan
This category will include children from _____percent of the FPL through _____percent of the FPL.

_____ Pregnant women above the income level specified in the State Plan

This category will include individuals from _____percent of the FPL through _____percent of the FPL.

_____ Parents above the current level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

__X_ Childless Adults (This category will include individuals from 0% percent of the FPL through 100% percent of the FPL.)

_____Pregnant Women in SCHIP (This category will include individuals from _____ percent of the FPL through _____percent of the FPL.)

__X_ Other. Please specify: Uninsured adults with children between 0% and 100% FPL (If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

_____Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

_____Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

__X_ Other. Please specify: Transitional clients between 65% and 185% FPL in second year of transition

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

_____ No
__X_ Yes

(If Yes) Number of participants n/a
or dollar limit of demonstration n/a

The program is "capped" in the sense that it will be limited by the State's SCHIP allotment and annual State appropriations.

Phase-in

_X_ The HIFA demonstration will be implemented at once. *

___ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline): * Individuals who are eligible for a second year of transitional Medicaid will move to the DHAP program on October 1, 2002.

Individuals who become eligible for certain existing optional Medicaid groups after October 1, 2002 will be enrolled in the new DHAP program. (Individuals who are receiving services on September 30, 2002 will continue to participate under the existing eligibility and program guidelines until their participation is terminated. If they reapply for services, their eligibility and participation will be subject to the revised Medicaid and new DHAP guidelines.)

Additional phases are dependent upon the State's economic outlook and the outcome of pending State legislation.

D. Benefit Package

Please use check marks to indicate
which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

_____ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

2. Optional populations included in the existing Medicaid State Plan

_____ The same coverage provided under the State's approved Medicaid State plan.
____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_X_ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

_____ The same coverage provided under the State's approved Medicaid State plan.

_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

_____ The same coverage provided under the State's approved Medicaid State plan.
_____ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.
and well-child care, including age appropriate immunizations.

5. Expansion Populations – States have flexibility in designing the benefit package, however,

the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a
basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

__X__ Inpatient
__X__ Outpatient
__X__ Physician's Surgical and Medical Services
__X__ Laboratory and X-ray Services
__X__ Pharmacy
__X__ Other (please specify): Same as existing SCHIP benefit with the exception of extended 31 day mental health benefits for adults, aged 18 or older.

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

E. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health insurance coverage	Group health plan coverage	Other (specify)
Mandatory					
Optional – Existing	X	X			
Optional – Expansion					
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP					
Existing section 1115 expansion	X	X			
New HIFA Expansion	X	X			

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

F. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

____ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check
all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment
D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

____ The same coverage provided under the State's approved Medicaid plan.

____ The same coverage provided under the State's approved SCHIP plan.

____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees.

____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

____ Secretary-Approved coverage.

____ Other coverage defined by the State. (A copy of the benefits description must be
included in Attachment D.)

____ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly
higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

____ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

G. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory		[redacted]	[redacted]
Optional – Existing (Children)			[redacted]
Optional – Existing (Adults)		X	
Optional – Expansion (Children)			[redacted]
Optional – Expansion (Adults)			
Title XXI – Medicaid Expansion			[redacted]
Title XXI – Separate SCHIP			[redacted]
Existing section 1115 Expansion		X	
New HIFA Expansion		X	

Cost-sharing for children

Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of March, 2000 for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

Persons by Poverty Status, Age Group, and Health Insurance Coverage (Average 1998-2000)

	Population		Less than 18 years of age		19 years of age or older	
	%age	Est. Number	%age	Est. Number	%age	Est. Number
Population below 100% FPL	10.4 %	79,784	16.7%	36,497	7.9%	43,287
Uninsured below 100% FPL	27.2 %	21,711	22.0%	8,016	31.6%	13,695
Pop. between 101% and 200%	15.9 %	122,413	20.0%	43,797	14.3%	78,616
Uninsured 101%–200% FPL	24.9 %	30,454	27.9%	12,225	23.2%	18,229
Total pop. below 200% FPL	26.3 %	202,197	36.7%	80,394	22.2%	121,903
Total uninsured below 200%	25.8 %	52,165	25.2%	20,241	26.2%	31,924
State population		768,260		218,698		549,571

"Delawareans without Health Insurance 2000" report by Center for Applied Demography and Survey Research, March 1998-2000

The coverage rates in your State for the insurance categories for individuals below 200 percent
of poverty and any other groups that will be covered under the demonstration project:

Uninsured 25.8%

Private Health Insurance Coverage Under a Group Health Plan 22.3%

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)
36.1%

Public Sector
5.5%

Medicare 7.1%

Other Insurance 3.2%

Indicate the data source used to collect the insurance information presented above (the State may
use different data sources for different categories of coverage, as appropriate):

__X_ The Current Population Survey

_____ Other National Survey (please specify_____)

_____ State Survey (please specify_____)

_____ Administrative records (please specify_____)

_____ Other (please specify_____)

Adjustments were made to the Current Population Survey or another national survey.

_X_ Yes _____ No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

_____ Yes _____ No

If yes, provide further details regarding the sample size of the survey and other important
design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration
on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was
providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing
the uninsured rate:

The number of uninsured will increase to 59,240 on October 1, 2002 when the TANF waiver that provides a second twelve-month period of Medicaid coverage expires for clients who are transitioning off of Medicaid. The goal of the DHAP program is to cover these clients under the HIFA waiver and reduce the projected uninsurance rate by 11.9%.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in
sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and
major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

__X__ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care,
quality of services provided, preventative care, and enrollee satisfaction. The performance plan
must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

__X__ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

_____ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package.

The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $ 58,473,445 over its _five_ year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social
Security Act (Please check all applicable):

Title XIX:

_____ **Statewideness 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

_____ **Amount, Duration, and Scope 1902(a)(10)(B)**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

_____ **Freedom of Choice 1902(a)(23)**

To enable the State to restrict the choice of provider.

Title XXI:

____ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

____ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

Title XIX:

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____ months of guaranteed eligibility to demonstration participants.

_____ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

__X__ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

____ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

_____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

__X__ Attachment B: Detailed description of expansion populations included in the demonstration.

__X__ Attachment C: Benefit package description.

_____ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

__X__ Attachment E: Detailed discussion of cost sharing limits.

__X__ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

__X__ Attachment G: Budget worksheets.

_____ Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

_____ Philip P. Soulé Sr., Deputy Director, Division of Social Services
Date Name of Authorizing State Official (Typed)

_____
Signature of Authorizing State Official

Attachment B: Detailed description of expansion populations in the demonstration

The expansion populations in the waiver include:

1. Uninsured adults up to 100 percent of the Federal Poverty level (FPL): As of March 1, 1996, the Diamond State Health Plan started approving applications from adults with family income at or below the poverty limit who are ineligible under any other Medicaid program and who have no comprehensive health insurance.

   Uninsured adults will be enrolled in the Delaware Healthy Adult Program as a logical Medicaid group to include in the new program. (Individuals who are receiving services on September 30, 2002 will participate under the existing eligibility and program guidelines until their participation is terminated. If they reapply for benefits after October 1, 2002, their eligibility and participation will be governed by the revised Medicaid or new DHAP program guidelines.)

2. Families who lose eligibility for Section 1931 due to new or increased earnings or loss of earned income disregards: This group of individuals currently remains eligible for Medicaid services for up to 24 additional months. However, effective September 30, 2002, the TANF waiver for this group will expire and their Medicaid coverage will be limited to 12 months. The state proposes to move this group into the new Delaware Healthy Adult Program for the second twelve-month coverage period on October 1, 2002. Without this new coverage, these individuals will contribute to an increase in the numbers of uninsured since they will lose medical assistance at the end of their twelve-month transition period.

Attachment C - Benefit package description

Services will be provided by the same managed care organizations (MCOs) that participate with Medicaid and the Delaware Healthy Children Program. The service package available to children in the DHCP will be provided to the Delaware Healthy Adult Program participants with one exception. The mental health/substance abuse benefit will offer the same 30 outpatient visit benefit, but adults will not receive 31 days of mental health or substance abuse treatment services (any modality) in a calendar year that is offered by the Delaware Healthy Children Program.

All other basic benefits required under HIFA will be included in the Delaware Healthy Adult Program.

Attachment D - Detailed description of private health insurance coverage options, including premium assistance

Employer Sponsored Insurance

The Delaware Health Care Commission (DHCC) is in the process of conducting an extensive program on the uninsured in Delaware. Titled the "Uninsured Action Plan", they are developing strategies for using employer based coverage to address some of the uninsured issues. Several models that include employer buy-in or small group employer initiatives are under review. The Department of Health and Social Services is a partner in these initiatives. The Division of Social Services will use the information generated by the DHCC to evaluate the feasibility of a pilot program for employer sponsored insurance (ESI) coverage.

Attachment E - Detailed discussion of cost sharing limits

There will be a premium for the Delaware Healthy Adult Program that must be paid in order to receive coverage. The premium is a nominal per family per month fee. Families must pay the premium at the time of enrollment to receive coverage. The premiums will be as follows:

- $10 per family per month for families with countable incomes greater than 100% and at or below 133% of the Federal Poverty Limit (FPL)
- $15 per month for families with incomes greater than 133% and at or below 166% of the FPL, and
- $25 per month for families with incomes greater than 166% and at or below 200% of the FPL

There will be a $10 copayment for inappropriate use of an emergency room.

Attachment F - Measuring Rate of Uninsurance/Progress

Estimates of insurance coverage for the population below 200% of the FPL are based on the distribution of types in the entire State population. This distribution was applied to the non-Medicaid population below 200% FPL to create pro-rated estimates for each category. If necessary, the University of Delaware has the capacity to provide additional statistics using income limits to present a more accurate picture of the distribution of insurance coverage types among population groups.

The strategic objectives for this waiver will be to:

1. decrease the number of uninsured adults under 200% FPL and thereby improve their health and chance for life success; and
2. mainstream uninsured adults in the health care industry so they have access to the same quality of care as insured adults.

The performance goals will be:

1. 11.9% decline in the rate of uninsured adults; and
2. 2% decline in unnecessary emergency room visits.

Reducing the number of uninsured adults

The Center for Applied Demographics at the University of Delaware prepares an annual report about access to health care, particularly the size and structure of the uninsured population, for the Delaware Health Care Commission. The report reviews the status of the uninsured in Delaware and the region, Delaware's labor market, and information on coverage for a variety of demographic variables.

The Center for Applied Demographics uses the Current Population Survey (CPS) as one of the data sources for its report. The report states that the sample size is "sufficient to produce statewide estimates on a wide variety of demographic indicators. When measuring the percentage of the population without health insurance, for example, the accuracy is approximately +/- 1.7%." (Delawareans Without Health Insurance, 2000, page 2)

DSS will track changes in the uninsured rate using the annual CPS data reported by the Center.

Access to Quality Health Care

Lacking access to other health care providers, the uninsured tend to use one of the most expensive providers, the emergency room, to address their health care needs. (Delawareans Without Health Insurance, 2000, Introduction). Participation in an insurance plan that offers care from an array of providers will reduce the number of inappropriate emergency room visits.

The State will use the first year of the HIFA waiver data to establish a baseline against which future emergency room utilization can be measured, using the best available encounter data from the Managed Care Organizations.

Appendix G - Budget Template

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds							
	Prev FY	**FFY 1**	**FFY 2**	**FFY 3**	**FFY 4**	**FFY 5**	**Total**
	FFY 02	**FFY 03**	**FFY 04**	**FFY 05**	**FFY 06**	**FFY 07**	**FFY 03 - FFY 07**
State's Allotment	$8,520,205	$8,775,811	$9,039,085	$9,563,352	$10,098,900	$10,674,537	$48,151,687
Funds Carried Over From Prior Year(s)	$19,542,018	$19,025,963	$17,296,016	$17,814,897	$18,602,438	$19,662,253	$92,401,566
SUBTOTAL (Allotment + Funds Carried Over)	$28,062,223	$27,801,774	$26,335,102	$27,378,249	$28,701,338	$30,336,790	$140,553,253
Reallocated Funds (Redistr/ Ret Currently Available)	$4,792,874	$0	$0	$0	$0	$0	$0
TOTAL (Subtotal + Reallocated funds)	**$32,855,097**	**$27,801,774**	**$26,335,102**	**$27,378,249**	**$28,701,338**	**$30,336,790**	$140,553,253
State's Enhanced FMAP Rate	65%	65%	65%	65%	65%	65%	65%
COST PROJECTIONS OF APPROVED SCHIP PLAN							
Benefit Costs							
Insurance payments							
Managed care	$2,510,776	$2,636,315	$2,768,130	$2,906,537	$3,051,864	$3,204,457	$14,567,302
per member/per month rate @ # of eligibles							
Fee for Service	$1,109,863	$1,165,356	$1,223,624	$1,284,805	$1,349,045	$1,416,497	$6,439,326
Total Benefit Costs	$3,620,638	$3,801,670	$3,991,754	$4,191,341	$4,400,909	$4,620,954	$21,006,628
(Offsetting beneficiary cost sharing payments)	($350,000)	($367,500)	($385,875)	($405,169)	($425,427)	($446,699)	($2,030,669)
Net Benefit Costs	$3,270,638	$3,434,170	$3,605,879	$3,786,173	$3,975,481	$4,174,255	$18,975,959
Administration Costs							
Personnel							
General administration							
Contractors/Brokers (e.g., enrollment contractors)	$321,404	$337,474	$354,348	$372,066	$390,669	$410,202	$1,864,760
Claims Processing	$42,000	$44,100	$46,305	$48,620	$51,051	$53,604	$243,680
Outreach/marketing costs							
Other							
Total Administration Costs	$363,404	$381,574	$400,653	$420,686	$441,720	$463,806	$2,108,440
10% Administrative Cap	$363,404	$381,574	$400,653	$420,686	$441,720	$463,806	$2,108,440
Federal Title XXI Share	$2,362,128	$2,480,234	$2,604,246	$2,734,458	$2,871,181	$3,014,740	$13,704,859
State Share	$1,271,915	$1,335,511	$1,402,286	$1,472,401	$1,546,021	$1,623,322	$7,379,539
TOTAL COSTS OF APPROVED SCHIP PLAN	**$3,634,043**	**$3,815,745**	**$4,006,532**	**$4,206,859**	**$4,417,202**	**$4,638,062**	$21,084,398

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds							
	Prev FY	**FFY 1**	**FFY 2**	**FFY 3**	**FFY 4**	**FFY 5**	**Total**
	FFY 02	**FFY 03**	**FFY 04**	**FFY 05**	**FFY 06**	**FFY 07**	**FFY 03 - FFY 07**
COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL							
Benefit Costs for Preg Women btwn 134-160% FPL (PC in XIX)							
Insurance payments							
Managed care rate		$393.00	$393.00	$415.79	$439.08	$464.11	
per member/per month rate @ # of eligibles		$37,728	$37,728	$44,905	$52,690	$61,263	$234,313
Fee for Service		$12,308	$12,308	$14,650	$17,189	$19,986	$76,441
Total Benefit Costs for - Preg Women 134-160%		**$50,036**	**$50,036**	**$59,556**	**$69,878**	**$81,249**	$310,755
Benefit Costs for Preg Women > 160% FPL (PB in XIX)							
Insurance payments							
Managed care rate		$393	$393	$415.79	$439.08	$464.11	
per member/per month rate @ # of eligibles		$47,160	$47,160	$54,884	$63,228	$72,401	$284,833
Fee for Service		$15,385	$15,385	$17,906	$20,627	$23,620	$92,923
Total Benefit Costs for Preg Women > 160%		**$62,545**	**$62,545**	**$72,790**	**$83,854**	**$96,021**	$377,756
Benefit Costs children >185% FPL (CB in XIX)							
Insurance payments							
Managed care		$144.50	$144.50	$152.88	$161.44	$170.64	
per member/per month rate @ # of eligibles		$24,276	$24,276	$25,684	$27,122	$28,668	$130,025
Fee for Service		$0	$0	$0	$0	$0	$0
Total Benefit Costs children >185% FPL (CB in XIX)		**$24,276**	**$24,276**	**$25,684**	**$27,122**	**$28,668**	$130,025
Benefit Costs expanded pop. Male 0-100% FPL in XIX							
Insurance payments							
Managed care		$239.18	$239.18	$253.05	$267.22	$282.46	
per member/per month rate @ # of eligibles		$949,545	$1,898,850	$2,049,199	$2,207,237	$2,379,726	$9,484,556
Fee for Service		$309,859	$619,638.95	$668,733	$720,272	$776,532	$3,095,035
Total Benefit Costs expanded pop. Male 0-100% FPL in XIX		**$1,259,403**	**$2,518,489**	**$2,717,932**	**$2,927,509**	**$3,156,258**	$12,579,591
Benefit Costs expanded pop.Female 0-100% FPL in XIX							
Insurance payments							
Managed care		$239.18	$239.18	$253.05	$267.22	$282.46	
per member/per month rate @ # of eligibles		$1,277,700	$2,555,638	$2,757,739	$2,970,418	$3,202,814	$12,764,308
Fee for Service		$846,493	$1,693,145	$1,827,050	$1,967,977	$2,121,867	$8,456,532
Total Benefit Costs expanded pop.Female 0-100% FPL in XIX		**$2,124,193**	**$4,248,783**	**$4,584,789**	**$4,938,394**	**$5,324,681**	$21,220,840
Benefit Costs 1931 pop. (Adults 33.93% >65% FPL in XIX							
Insurance payments							
Managed care		$239.18	$239.18	$253.05	$267.22	$282.46	
per member/per month rate @ # of eligibles		$1,813,224	$1,813,224	$1,937,351	$2,066,412	$2,206,013	$9,836,223
Fee for Service		$591,697	$591,697	$632,232	$674,318	$719,848	$3,209,792
Total Benefit Costs 1931 pop. (Adults 33.93% >65% FPL in XIX)		**$2,404,921**	**$2,404,921**	**$2,569,583**	**$2,740,730**	**$2,925,860**	$13,046,015
Benefit Costs Work Transistion Pop (Adults 39.87%> 12 mons in XIX							
Insurance payments							
Managed care		$239.18	$239.18	$253.05	$267.22	$282.46	
per member/per month rate @ # of eligibles		$2,671,641	$2,671,641	$2,826,569	$2,984,847	$3,155,078	$14,309,775
Fee for Service		$871,819	$871,819	$922,419	$974,024	$1,029,539	$4,669,619
Total Costs Work Transistion Pop (Adults 39.87%> 12 mons in XIX)		**$3,543,459**	**$3,543,459**	**$3,748,987**	**$3,958,871**	**$4,184,617**	$18,979,394
Total Benefit Costs		**$9,468,833**	**$12,852,509**	**$13,779,320**	**$14,746,359**	**$15,797,353**	$66,644,375
(Offsetting beneficiary cost sharing payments)		($184,016)	($184,016)	($195,351)	($206,986)	($219,528)	($989,896)
Net Benefit Costs		$9,284,817	$12,668,494	$13,583,969	$14,539,373	$15,577,826	$65,654,479

HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds							
	Prev FY	FFY 1	FFY 2	FFY 3	FFY 4	FFY 5	Total
	FFY 02	FFY 03	FFY 04	FFY 05	FFY 06	FFY 07	FFY 03 - FFY 07
Administration Costs							
Personnel		$100,000	$105,000	$110,250	$115,763	$121,551	$552,563
General administration							
Contractors/Brokers (e.g., enrollment contractors)		$462,526	$485,652	$467,934	$449,331	$429,798	$2,295,240
Claims Processing		$52,270	$72,849	$77,452	$82,346	$87,548	$372,465
Outreach/marketing costs							
Other (specify)							
Total Administration Costs		$614,795	$663,501	$655,636	$647,439	$638,897	$3,220,269
10% Administrative Cap		$1,031,646	$1,407,610	$1,509,330	$1,615,486	$1,730,870	$7,294,942
Federal Title XXI Share		$6,434,748	$8,665,797	$9,255,744	$9,871,428	$10,540,870	$44,768,586
State Share		$3,464,864	$4,666,198	$4,983,862	$5,315,384	$5,675,853	$24,106,162
TOTAL COSTS FOR DEMONSTRATION		**$9,899,612**	**$13,331,995**	**$14,239,606**	**$15,186,812**	**$16,216,722**	**$68,874,747**
TOTAL PROGRAM COSTS (State Plan + Demonstration)		**$13,715,357**	**$17,338,527**	**$18,446,464**	**$19,604,014**	**$20,854,784**	**$89,959,146**
Total Fed Title XXI Funding Cur Avail (Allotmt + Realloc Funds)		$27,801,774	$26,335,102	$24,628,412	$22,737,110	$20,669,039	$122,171,436
Total Federal Title XXI Program Costs (State Plan + Demo)		$8,914,982	$11,270,042	$11,990,202	$12,742,609	$13,555,610	$58,473,445
Unused Title XXI Funds Expiring (Allotment or Reallocated)		$1,590,776	$0	$0	$0	$0	$1,590,776
Remaining Title XXI Funds to be Carried Over		$17,296,016	$15,065,059	$12,638,210	$9,994,501	$7,113,429	
(Equals Available Funding - Costs - Expiring Funds)							
TOTAL XXI FUNDS AVAILABLE		**$17,296,016**	**$15,065,059**	**$12,638,210**	**$9,994,501**	**$7,113,429**	
State allotment increases - Source: CMS - 21 January, 2002 and CMS - 21B February, 2002; Nat. Health Care Expenditures - Hospital Care Exp's Aggregate and Per Capita							
Amts - Av. Ann. %age Change by Funding Source - Medicaid FFY 05 to 07			FY 03 - 3%; FY 04 - 3%; FY 05 - 5.8%; FY 06 - 5.6%; FY 07 - 5.7%				
Beneficiary cost sharing payments = 5% of benefit costs for groups over 100% FPL							
Expenditure increases							
FFY 02 projection; FFY 03 to 07 expenditures increased 5% annually							